BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **STEVEN C. TORRES, M.D.** Holder of License No. **31282** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0072A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 12, 2006. Steven C. Torres, M.D., ("Respondent") appeared with legal counsel Calvin L. Raup before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 31282 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0072A after receiving a complaint regarding Respondent's care and treatment of a sixteen year-old female patient ("EG"). EG was gravida 2, para 0 when she presented to the emergency department with vomiting. EG had a history of insulin dependent diabetes. The medical records indicate she was listed as 23 to 24 weeks pregnant, but she was actually 33 weeks pregnant. Treatment with a D5 normal saline was initiated after EG's initial blood sugar was found to be 180. An Accu-Chek was subsequently done and the blood sugar was 446. Respondent ordered only the Accu-Chek and a urinalysis. The urine showed positive ketones, positive glucose, and positive protein. Respondent was

aware of these findings. At the end of his shift Respondent signed out to another physician. There is no note of any consultation or indication of any plan for EG. EG was later discharged from the emergency department and three hours later she arrived in the obstetrical department in active labor with spontaneous rupture of membranes and delivered a stillborn infant. EG was in diabetic ketoacidosis ("DKA") with a pH of 7.1.

4. Respondent's own retrospective review of the record found some errors in EG's care. Respondent was the only physician in the emergency department and there was a physician assistant available. The emergency department was very busy and he was taking care of a critically unstable patient when the charge nurse approached him with EG's chart and told him she had "a hyperemesis in Room 5" and asked him to see her. Respondent testified he was told EG was 23 weeks pregnant. Respondent admitted he should have triaged EG to labor and delivery at that time, but he was in an unstable situation so he told the nurse to put an IV in and he wrote orders as he usually would for someone who came in with hyperemesis. Respondent testified he was not told EG was an insulin-dependent diabetic and was only told she was hyperemesis and 23 weeks pregnant.

5. Respondent testified three hours passed and for approximately two and three-quarter hours EG did not vomit and she looked good when he examined and spoke to her. EG was alone and said she felt ill and had been vomiting all day. Respondent testified EG looked at least 23 weeks pregnant and he did not measure her uterus. Respondent testified EG did not appear toxic and certainly did not appear DKA. Respondent testified he never saw the Accu-Chek of 180 and it was his fault he did not ask for the number. When Respondent was preparing for sign-out he had everything wrapped up except EG and he told the physician he was signing-out to that EG was hyperemesis, looked good, was not vomiting, was being hydrated, and her vital signs were stable. Respondent testified at this point the nurse approached and told him the Accu-Chek was 446 and he told the nurse that changed everything and told the on-coming

physician EG was sick and he did not realize she was an insulin-dependent diabetic. Respondent testified he believes he made three errors – not immediately sending EG to labor and delivery; not getting or demanding to see the chart, which would have given him clues EG was an insulin dependent diabetic; and not ordering labs to rule out DKA prior to leaving.

6. Respondent testified that when he examined EG he did not ask, and she did not volunteer, that she was an insulin dependent diabetic. The Board asked at what range of pregnancy does hyperemesis occur. Respondent testified it certainly occurs mostly early on, in the first trimester, but it can also occur throughout an entire pregnancy. Respondent testified he did examine EG's belly and was mainly concerned that she was not tender and she denied vaginal bleeding or discharge and never complained of abdominal pain. Respondent testified his attention was not really directed toward her pregnancy since he was told she was only 23 weeks along.

7. The Board confirmed Respondent was aware of the fetal heart tones recorded at 180 and asked whether that triggered his thoughts that something may be wrong. Respondent testified it did raise a little bit of a red flag, but he attributed the 180 to EG's dehydration. Respondent testified he would not necessarily draw blood in hyperemesis and his initial orders would check the urine to get a specific gravity, to learn how dehydrated the patient is, and let him check the ketones. Respondent also testified he normally checks an Accu-Chek and starts hydrating the patient and gives them an antiemetic. If the patient continues to do poorly, and he feels he has to admit the patient, he will then order labs.

8. Respondent noted his conversation with the physician who was coming on duty and stated his biggest mistake may have been not having the chart to circle the labs and write out orders and not signing out the patient. Respondent now writes in the chart the name of the physician he transfer care to and, if he wants something done, he writes it in the chart then and there. Respondent also noted he makes sure to look at the chart thoroughly and in a timely

manner because he thinks one of his biggest faults in EG's case was not taking the chart and looking at it carefully and he should have stopped and immediately gone to look at the chart. As a result of this case Respondent obtained thirteen hours continuing medical education in high-risk obstetrics.

9. The Board clarified the history Respondent was given was one day of vomiting and asked if he was comfortable just checking the urine and not doing blood work. Respondent testified initially he only checks the urine. The Board asked if a history of one day vomiting requires blood work. Respondent testified he sees hyperemesis all the time and his initial orders depend on how the patient looks and the vital signs and he may add orders later on if the patient is not doing well – if they continue to vomit and their heart rate is 130 for example.

10. The Board asked whether there was any protocol or recommendations that existed at the hospital regarding pregnant diabetic patients that present to the emergency department. Respondent testified anyone over 20 weeks is supposed to go to labor and delivery and not the emergency department. Respondent testified he should have never gotten EG as a patient. Respondent stated every pregnant DKA that comes into the emergency department needs an obstetrics/gynecology ("OB/GYN") consultation, but he did not have this diagnosis. He had the suspicion when he left that it was DKA. The Board confirmed Respondent was aware of the urinalysis results, the degree of ketosis that was shown, before he left and asked if he believed EG would ultimately be discharged or probably be admitted. Respondent testified an Accu-Chek of 446 needs to be ruled out for DKA, but EG looked good, was not tachypneic, her heart rate was 98, and she never complained of abdominal pain – she did not look like DKA, so he can see how she would have been discharged. Respondent testified it was a hard call whether to discharge or admit, but he would have done her labs and, if she was not acidosis at all, would have called OB/GYN and given them her labs and told them her status and asked whether he should do an ultrasound. Respondent could not say for sure EG should have been admitted

when he left. Respondent no longer practices at the hospital where these events took place because he believes it was understaffed.

11. The standard of care required Respondent to appropriately evaluate and manage a pregnant patient with diabetic ketoacidosis, including confirming how many weeks pregnant the patient is, performing a careful abdominal examination, admitting the patient with obstetric attendance and involvement, and ordering basic laboratory studies, such as blood glucose.

12. Respondent deviated from the standard of care because he did not appropriately evaluate and monitor a pregnant patient with diabetic ketoacidosis.

13. EG developed severe DKA causing the death of the fetus and she required prolonged hospitalization for DKA.

14. It is mitigating that Respondent completed the continuing medical education in high risk obstetrics, that there were systems errors, and that EG was a non-compliant diabetic.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to 32-1401(27)(q)("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public") and 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failure to recognize diabetic ketoacidosis in a pregnant patient.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 7th day of December, 2006.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 8th day of December, 2006 with:
Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 8th day of December, 2006, to:

Calvin L. Raup
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Steven C. Torres, M.D.
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